DEPENDENT CARE SPENDING ACCOUNT
CLAIM FOR REIMBURSEMENT

Name of Employer _____

Employee Name _____ **Social Security** _____

Employee Address _____
Street **City**

_____
State **Zip**

Dependent Name	**Date of Birth**	**Relationship to Employee**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please complete the information below and attach corresponding bills or receipts with dates of service for each listed provider.

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Tax I.D. or _____ Tax I.D. or _____

Soc. Sec. # _____ Soc. Sec. # _____

Dates of Service: _____ to _____ Dates of Service: _____ to _____

If dependent care was provide in your home, complete the following:

Household Services Relating To The Care Of A Qualifying Individual (s)	$ _____
FICA and FUTA Taxes on Wages Paid To A Housekeeper	$ _____
Room And Board Expenses Incurred Outside The Home For A Housekeeper	$ _____
Transportation Expenses of A Housekeeper	$ _____
Other (please list)	
_____	$ _____
_____	$ _____
_____	$ _____

If your eligible expenses were incurred outside of your home, complete the following:

Services Related To The Care Of Qualified Individual(s) And Incurred in A Day Care Provider's Home/Day Care Center	$ _____
TOTAL DEPENDENT CARE REIMBURSEMENT REQUESTED:	$ _____

CERTIFICATION

I certify that I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Flexible Spending Account. I further declare that I have not and will not deduct these expenses on my Individual Income Tax Returns. I certify that the above eligible expenses have been (or will be) paid for the care of a qualified individual(s).

EMPLOYEE SIGNATURE _____ DATE _____

MAIL COMPLETED FORM TO:

BROWN & BROWN of NEW YORK, INC.
DBA FITZHARRIS & COMPANY
333 Earle Ovington Blvd., Suite #215
Uniondale, NY 11553-3624
(516) 944-2823; FAX (516) 944-2953